STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	06/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Post Survey Revisit [PSR] to the Recertification and State Licensure Survey completed on May 12, 2011. Survey Dates: June 27, 28, 2011 Facility number: 002657 Provider number: 155681 Aim number: 200308930 Survey team: Avona Connell, RN TC Donna Groan, RN Dorothy Navetta, RN Gloria Reisert, MSW Census bed type: SNF: 38 SNF/NF: 37 Total: 75 Census payor type: Medicare: 24 Medicaid: 19 Other: 32 Total: 75 Sample: 09 Supplemental sample: 03 These deficiencies also reflect State	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Findings cited in accordance with 410 IAC 16.2. Quality review completed 6/29/11 Cathy Emswiller RN			
F0155 SS=D	The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. Based on record review, observation and interview, the facility failed to allow 1 of 1 resident requiring insertion of an intravenous fluid line [IV] in a supplemental sample of 3 the right to refuse treatment even after the resident informed the staff she did not want the IV. (Resident #29) Finding includes: Review of the clinical record for Resident #29 on 6/27/2011 at 2:00 p.m., indicated the resident had diagnoses which included, but were not limited to, shingles of the vaginal area, dementia with disturbance of mood and behavior,	F0155	1. Resident #29 reassessed with no signs of distress or recollection of procedure.2. All residents these employees care for have the potential to be affected and therefore the IV nurse, LPN #3 , and CNA #1 were re-educated by Home Office Clinical Support on a resident's right to refuse treatment accessed from the Indiana State Ombudsman program.3. All staff were re-inserviced by Home Office Clinical Support or DHS on a resident's right to refuse treatment accessed from the Indiana State Ombudsman program.4. Rounding will be conducted by the Social Worker or designee to include visually monitoring of staff adherence to	07/22/2011

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	depression and insomnia. A nursing note dated 6/27/2011 at 8:00 a.m. indicated the resident was not eating or taking fluids or meds and the daughter was concerned the infection might get worse or that the resident would become dehydrated. The note also indicated the resident was in a very foul mood slapping at staff during care and screaming out. A new order from the physician was received for staff to attempt to place a midline [IV]. At 1:00 p.m., the IV nurse arrived and began the process of inserting the special line with LPN #3 assisting him. Although the nurse could be heard trying to reassure the resident and explain the procedure, the resident could be heard from behind the closed doors yelling out "Oh no you don't. Get away. No." A few minutes later, LPN #3 requested CNA #1 [certified nursing assistant] to come into the room and help her with the resident while they were trying to get the IV in. The resident continued to yell. Between 1:30 p.m. and 2:00 p.m. during the observation of the IV procedure, while the IV nurse was on the left side trying to get the line in and telling the resident to hold still, LPN #3 was observed to be holding the resident's right hand with her		Resident Rights in addition to interviewing a minimum of one resident during each round. This will occur a minimum of 5 times per week for 1 month and 3 times per week for 2 months. Results of this rounding and interviews will be reviewed by the QA Committe and if 100% compliance is not reached, then rounding and interviews will continue until 3 months of consistent compliance of 100% is reached.	

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	other arm across the resident's chest. CNA #1 was observed to be holding down one to both of the resident's legs off and on so she would not move during the procedure. Throughout this observation, the resident was heard to yell for the staff to get off her legs to which the LPN and IV nurse replied that they could not as they were not done yet, she "hated" them, "get off me", and at one point while looking at the IV nurse, tell him twice "Please, you're hurting my arm." The LPN and the CNA continued to hold the resident's legs and chest/hand until the procedure was done. At the end of the procedure, the resident's left arm was observed to be stretched out and taped to the overbed table at the wrist. She also remained vocal in telling the staff to get out and "Oh, I hurt" with yelling out while attempting to take her to the bathroom per her request. During an interview with LPN #3 on 6/27/2011 at 2:10 p.m., she indicated the reason she did not let the resident refuse the insertion of the IV was because she did not feel the resident understood nor comprehended the idea that it was for her own good and would help her for it to be placed. She felt the resident could not make a choice to refuse and it was the daughter's request for her to have it.			

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	During an interview with the Administrator and DoN [Director of Nursing] on 6/27/2011 at 2:35 p.m., both indicated the staff should have stopped what they were doing and notified the physician she was combative. On 6/28/2011 at 8:55 a.m., the DoN presented a copy of the "Resident Rights" and "Move in Handbook" given to residents and families at the time of admission. Review of these papers included, but were not limited to, "...page 18: You have the right to refuse your nursing care and medical treatment...This means that: 1. You...may refuse your nursing care and medical treatment..." 3.1-4(d)			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review, observation and interview, the facility failed to notify the physician when 1 of 1 resident in a supplemental sample of 3 became combative and refusing the insertion of a midline IV, [intravenous fluid line], but the IV was done anyway. (Resident #29)	F0157	1. Resident #29 reassessed with no signs of distress or recollection of procedure.2. All residents these employee care for have the potential to be affected and therefore the IV nurse, LPN #3 , and CNA #1 were re-educated by Home Office Clinical Suport or DHS on a resident's right to refuse	07/25/2011

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	Finding includes: Review of the clinical record for Resident #29 on 6/27/2011 at 2:00 p.m., indicated the resident had diagnoses which included, but were not limited to, shingles of the vaginal area, dementia with disturbance of mood and behavior, depression and insomnia. A note in the nursing notes dated 6/27/2011 at 8:00 a.m. indicated the resident was not eating or taking fluids or meds and the daughter was concerned the infection might get worse or that the resident would become dehydrated. The note also indicated the resident was in a very foul mood slapping at staff during care and screaming out. A new order from the physician was received for staff to attempt to place a midline [IV]. At 1:00 p.m., the IV nurse arrived and began the process of inserting the special line with LPN #3 assisting him. Although the nurse could be heard trying to reassure the resident and explain the procedure, the resident could be heard from behind the closed doors yelling out "Oh no you don't. Get away. No." A few minutes later, LPN #3 requested CNA #1 [certified nursing assistant] to come into the room and help her with the resident while they were		treatment as oulined by the Indiana State Ombudsman program and the importance of MD notification in the event this right is exercised. 3. All staff were re-inserviced by Home Office Clinical Suport or DHS on a resident's right to refuse treatment as oulined by the Indiana State Ombudsman program and the importance of MD notification in the event this right is exercised. 4. Rounding will be conducted by the Social Worker or designee to include visually monitoring of staff adherence to Resident Rights in addition to interviewing a minimum of one resident during each round. This will occur a minimum of 5 times per week for 1 month and 3 times per week for 2 months. Results of this rounding and interviews will be reviewed by the QA Committe and if 100% compliance is not reached, then rounding and interviews will continue until 3 months of consistent compliance of 100% is reached.	

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	trying to get the IV in. The resident continued to yell. Between 1:30 p.m. and 2:00 p.m. during the observation of the IV procedure, while the IV nurse was on the left side trying to get the line in and telling the resident to hold still, LPN #3 was observed to be holding the resident's right hand with her other arm across the resident's chest. CNA #1 was observed to be holding down one to both of the resident's legs off and on so she would not move during the procedure. Throughout this observation, the resident was heard to yell for the staff to get off her legs to which the LPN and IV nurse replied that they could not as they were not done yet, she "hated" them, "get off me", and at one point while looking at the IV nurse, tell him twice "Please, you're hurting my arm." The LPN and the CNA continued to hold the resident's legs and chest/hand until the procedure was done. At the end of the procedure, the resident's left arm was observed to be stretched out and taped to the overbed table at the wrist. She also remained vocal in telling the staff to get out and "Oh, I hurt" with yelling out while attempting to take her to the bathroom per her request. During an interview with LPN #3 on 6/27/2011 at 2:10 p.m., she indicated the			

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	reason she did not let the resident refuse the insertion of the IV was because she did not feel the resident understood nor comprehended the idea that it was for her own good. During an interview with the Administrator and DoN [Director of Nursing] on 6/27/2011 at 2:35 p.m., both indicated the staff should have stopped what they were doing and notified the physician she was combative. On 6/28/11 at 8:30 a.m., the clinical record was reviewed for Resident #29 and documentation was lacking in the nurses notes of the physician being notified during and/or after the IV insertion related to the residents behavior. This deficiency was cited on 5/27/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-5(a)(3)			
F0224 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. A. Based on record review, observation	F0224	1. a. Resident #29 reassessed with no signs of distress or	07/25/2011

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	and interview, the facility failed to allow 1 of 1 resident requiring insertion of an intravenous fluid line [IV] in a supplemental sample of 3 the right to refuse treatment even after the resident informed the staff she did not want the IV. (Resident #29) B. Based on record review and interview the facility failed to ensure resident medication was secure for 2 of 2 residents reviewed with missing medications in a supplemental sample of 3. (Resident #78, 79) Findings include: A. 1. Review of the clinical record for Resident #29 on 6/27/2011 at 2:00 p.m., indicated the resident had diagnoses which included, but were not limited to, shingles of the vaginal area, dementia with disturbance of mood and behavior, depression and insomnia. A note in the nursing notes dated 6/27/2011 at 8:00 a.m. indicated the resident was not eating or taking fluids or meds and the daughter was concerned the infection might get worse or that the resident would become dehydrated. The note also indicated the resident was in a very foul mood slapping at staff during care and screaming out. A new order		recollection of procedure. b. Both Residents#78 & #79 continued to receive medications as ordered and neither received a bill for the misappropriated medications. 2. a. All residents these employees are for have the potential to be affected and therefore the IV nurse, LPN #3 , and CNA #1 were re-educated by Home Office Clinical Suport regarding the federal and state regulation regarding mistreatment, neglect and abuse of residents. b. LPN #2 and RN#1 were terminated. All current resident records were reviewed to ensure no other resident medications were missappropriated with no additional findings.3. All staff were re-educated by Home Office Clinical Suport or DHS regarding the federal and state regulation regarding mistreatment, neglect and abuse of residents and misappropriation of property. In addition, all nurses and QMAs were in-serviced on the revised campus controlled drug destruction policy which includes nursing adminstration and another staff nurse jointly conducting the destruction as recommended per PCA Pharmaceutical.4. a. Rounding will be conducted by the Social Worker or designee to include visually monitoring of staff adherence to Resident Rights/Abuse Prevention in addition to interviewing a	

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	from the physician was received for staff to attempt to place a midline [IV]. At 1:00 p.m., the IV nurse arrived and began the process of inserting the special line with LPN #3 assisting him. Although the nurse could be heard trying to reassure the resident and explain the procedure, the resident could be heard from behind the closed doors yelling out "Oh no you don't. Get away. No." A few minutes later, LPN #3 requested CNA #1 [certified nursing assistant] to come into the room and help her with the resident while they were trying to get the IV in. The resident continued to yell. Between 1:30 p.m. and 2:00 p.m. during the observation of the IV procedure, while the IV nurse was on the left side trying to get the line in the resident's arm and telling the resident to hold still, LPN #3 was observed to be holding the resident's right hand with her other arm across the resident's chest. CNA #1 was observed to be holding down one to both of the resident's legs off and on so she would not move during the procedure. Throughout this observation, the resident was heard to yell for the staff to get off her legs to which the LPN and IV nurse replied that they could not as they were not done yet, she "hated" them, "get off		minimum of one resident during each round. This will occur a minimum of 5 times per week for 1 month and 3 times per week for 2 months. Results of this rounding and interviews will be reviewed by the QA Committe and if 100% compliance is not reached, then rounding and interviews will continue until 3 months of consistent compliance of 100% is reached. b. The DHS or designee will conduct audits of 5 residents one time per week for 3 months by obtaining a controlled substane delivery report from the pharmacy and cross-checking this information with the correlating resident narcotic count sheet, and the actual narcotic count. Results of this audit will be reviewed by the QA committee and continue monthly until 3 months of 100% compliance is reached.	

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	me", and at one point while looking at the IV nurse, tell him twice "Please, you're hurting my arm." The LPN and the CNA continued to hold the resident's legs and chest/hand until the procedure was done. At the end of the procedure, the resident's left arm was observed to be stretched out and taped to the overbed table at the wrist. She also remained vocal in telling the staff to get out and "Oh, I hurt" with yelling out while attempting to take her to the bathroom per her request. During an interview with LPN #3 on 6/27/2011 at 2:10 p.m., she indicated the reason she did not let the resident refuse the insertion of the IV was because she did not feel the resident understood nor comprehended the idea that it was for her own good and would help her for it to be placed. She felt the resident could not make a choice to refuse and it was the daughter's request for her to have it. During an interview with the Administrator and DoN [Director of Nursing] on 6/27/2011 at 2:35 p.m., both indicated the staff should have stopped what they were doing and notified the physician she was combative. Review of the Care Plans for Resident #29 included the following care plan with an implementation date of 1/10 and			

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	review dates of 9/6/10, 12/6/10, and 3/10/11: "Problem: Behavior Problem - Physically Abusive, Socially Inappropriate, Verbally Abusive, Resists Care, negative, means statements to staff, yelling out." Interventions included, but were not limited to, "Provide non-confrontational environment for care; Anticipate care needs and provide them before the resident becomes overly stressed. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, person involved, etc. Explain all procedures before starting and allow time to adjust. Reapproach resident later when she becomes agitated". Documentation and/or observation of these interventions being attempted were lacking prior to and during the procedure. On 6/27/2011 at 1:00 p.m., the DoN presented a copy of the facility's current policy and procedure on "Abuse and Neglect - Procedural Guidelines". Review of this policy at this time included, but was not limited to, "Purpose: [facility name] has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Procedure: 1. [facility name] had implemented processes in an effort to provide a comfortable and safe			

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	environment..." On 6/28/2011 at 8:55 a.m., the DoN presented a copy of the most recent inservice given to all staff on "Resident Rights/Abuse" dated 3/31/2011. Review of the signature page indicated LPN #3 and CNA #1 had attended this inservice. Review of the content of information given to the staff included, but was not limited to, "Prevention and Reporting of Suspected Resident/Patient Abuse and Neglect:...Training: a. provide training for new employees through orientation and with ongoing training programs...2. Training will include, but is not limited to:...Appropriate interventions to deal with aggressive or catastrophic reactions of residents..b. Documentation of training will be maintained with inservice records in the facility....3. Prevention: a. Assure that prevention techniques are implemented in the campus. Identify, correct, and intervene in situations where abuse and/or neglect are more likely to occur. These may include, but are not limited to, an analysis of:...Assigned staff demonstrate knowledge of individual resident needs. Identification of residents with needs and/or behaviors which might lead to conflict or neglect... B. On 6/6/11 at 7:25 a.m., the			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator reported the following incident: "On evening of June 6th, LPN (Licensed Practical Nurse) #1 called the DHS (Director of Health Services) and reported that 22 vials of Morphine and narcotic sheet were missing. It was reported that [named] LPN #2, removed the vials of morphine to destroy these narcotics with [named] RN (registered nurse) #1. The physician had given an order to discontinue administration of this medication for the resident involved (Resident #78). Upon investigation, the morphine vials were not found and the narcotic sign out sheet was missing. Neither nurse can accurately account for the morphine vials or narcotic sheet. Upon investigation, it was determined that the physician had not given an order to discontinue the morphine. Investigation also noted that [named] LPN #2 and [named] RN #1 had wasted 10 doses of Lortab (pain narcotic) for another resident (Resident #79) that there was not an order to discontinue the medication. The local police are involved with the facility in the ongoing investigation." 1. The clinical record for Resident #78 was reviewed on 6/27/11 at 1:45 p.m. The resident's diagnoses included, but were not limited to arthritis. Physician's Telephone Orders dated 5/28/11 included, but was not limited to; "Morphine 2 mg			

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	155681	A. BUILDING 00 B. WING	06/28/2011

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	(milligram) q. (every) 4 hour prn (as needed) pain IV (intravenous) or IM (intramuscularly); Morphine 4 mg q. 4 hour prn severe pain..." Subsequent Physician's Telephone Orders on 5/30, 5/31, 6/5 and 6/6 lacked any discontinuation of Morphine orders. 2. The clinical record for Resident #79 was reviewed on 6/27/11 at 1:50 p.m. The resident was admitted to the facility on 4/25/11 with a recent pelvic fracture. The resident's diagnoses included, but were not limited to: arthritis and temporal arthritis. Signed and dated orders for May 2011 included, but was not limited to: Lortab 5/500 tablet Give 1 tablet orally every 4 hours as needed for moderate to severe pain... " Physician's Telephone Orders on 5/27, and 6/3 lacked any discontinuation of Lortab. In interview with the DON on 6/27/11 at 12 p.m., she indicated LPN #2 admitted to the police she had taken 11 vials and RN #1 took 11 vials. On 6/28/11 at 12:20 p.m., the DHS provided the Inservice Resident Rights\HIPAA (Health Insurance Portablility & Accountability Act)\Abuse which was conducted on 3/31/11. LPN #2 was listed in attendance while RN #1 was not. The Policy revised on 11/2005			

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	TOPIC: Prevention and Reporting of Suspected Resident/Patient Abuse and Neglect included, but was not limited to: Definitions: Misappropriation of Property - includes, but is not limited to the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or funds." On 6/27/11 at 12:10 p.m., the DHS provided a Narcotic In-Service form signed on 4/4/11 by RN #1 and on 3/28/11 by LPN #2 which included, but was not limited to: "Wasting narcotics: When a medication has been discontinued, patient discharged, medication expired or cartridge is completed. 2 nurses MUST waste the medication together and document the date of destruction; number of medication destroyed and both nurses MUST sign the narcotic sheet...Then file the narcotic sheet in the patients chart..." On 6/27/11 at 12:17 p.m., the DHS indicated LPN#2 and RN #1 had planned on dividing the Morphine and RN #1 took the narcotic sheet(s). She indicated both nurses were terminated. 3.1-27(a)(1) 3.1-28(a)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview the facility failed to ensure the policy and procedure for drug destruction was followed for 2 of 2 residents reviewed for drug destruction in a supplemental sample of 3. (Resident #78, 79) Findings include: On 6/6/11 at 7:25 a.m., the facility reported the following incident: "On evening of June 6th, LPN (Licensed Practical Nurse) #1 called the DHS (Director of Health Services) and reported that 22 vials of Morphine and narcotic sheet were missing. It was reported that [named] LPN #2, removed the vials of morphine to destroy these narcotics with [named] RN (registered nurse) #1. The physician had given an order to discontinue administration of this medication for the resident involved (Resident #78). Upon investigation, the morphine vials were not found and the narcotic sign out sheet was missing. Neither nurse can accurately account for the morphine vials or narcotic sheet. Upon investigation, it was determined that the physician had not given an order to discontinue the morphine. Investigation	F0282	1. Both Residents#78 & #79 continued to receive medications as ordered and neither received a bill for the misappropriated medications. 2. LPN #2 and RN#1 were terminated. All current resident contolled substance records were reviewed to ensure no other resident medications were missappropriated with no additional findings.3. All nurses and QMAs were in-serviced by the Home Office Clinical Support or DHS on the revised campus controlled drug destruction policy which includes nursing adminstration and another staff nurse jointly conducting the destruction as recommended per PCA Pharmaceutical. 4. The DHS or designee will conduct audits of 5 residents one time per week for 3 months by obtaining a controlled substane delivery report from the pharmacy and cross-checking this information with the correlating resident narcotic count sheet, and the actual narcotic count. Results of this audit will be reviewed by the QA committee and continue monthly until 3 months of 100% compliance is reached.	07/25/2011

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	also noted that [named] LPN #2 and [named] RN #1 had wasted 10 doses of Lortab (pain narcotic) for another resident (Resident #79) that there was not an order to discontinue the medication. The local police are involved with the facility in the ongoing investigation." 1. The clinical record for Resident #78 was reviewed on 6/27/11 at 1:45 p.m. The resident's diagnoses included, but were not limited to arthritis. Physician's Telephone Orders dated 5/28/11 included, but was not limited to; "Morphine 2 mg (milligram) q. (every) 4 hour prn (as needed) pain IV (intravenous) or IM (intramuscularly); Morphine 4 mg q. 4 hour prn severe pain..." Subsequent Physician's Telephone Orders on 5/30, 5/31, 6/5 and 6/6 lacked any discontinuation of Morphine orders. 2. The clinical record for Resident #79 was reviewed on 6/27/11 at 1:50 p.m. The resident was admitted to the facility on 4/25/11 with a recent pelvic fracture. The resident's diagnoses included, but were not limited to: arthritis and temporal arthritis. Signed and dated orders for May 2011 included, but was not limited to: Lortab 5/500 tablet Give 1 tablet orally every 4 hours as needed for moderate to severe pain... " Physician's Telephone Orders on 5/27, and 6/3 lacked any			

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	discontinuation of Lortab. The [named] Pharmacy Controlled Drug Record for Resident #79 for "Hydrocodone/APAP (tylenol) 5/500 tablets Gen (generic) for: Lortab 5/500 tablet was received on 4/25/11, at which time, 15 tablets were sent. Five (5) doses had been given to Resident #79. Disposition of remaining Doses indicated Doses flushed quantity 10 date 5/26/11 RN #1 and LPN #2". Nursing staff failed to have an order for the drug destruction. On 6/27/11 at 12:10 p.m., the DHS provided a Narcotic In-Service form signed on 4/4/11 by RN #1 and on 3/28/11 by LPN #2 which included, but was not limited to: "By signing below, I am attesting to understanding and agreeing to follow the narcotic policy and procedure. I am also aware of the new narcotic form that must be completed when a narcotic is received, wasted or empties. I also understand the policy on administering narcotics and the forms that are required to fill out per Trilogy's Policy...Wasting narcotics: When a medication has been discontinued, patient discharged, medication expired or cartridge is completed. 2 nurses MUST waste the medication together and document the date of destruction; number of medication destroyed and both nurses MUST sign the narcotic sheet...Then file the narcotic			

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	sheet in the patients chart..." On 6/27/11 at 12 p.m., the Corporate Nurse Consultant indicated RN #1 had the Narcotic inservice on April 4, 2011. On 6/27/11 at 12:17 p.m., the DHS indicated LPN #2 and RN #1 had wasted the medication for Resident #79. She indicated both nurses were terminated. This deficiency was cited on 05/12/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-35(g)(2)			
F9999		F9999	No deficiency cited.	07/25/2011